

THE
CHILD

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WHEN A CHILD HAS CEREBRAL PALSY

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CEREBRAL PALSY, or "cerebral spastic paralysis," is becoming one of the greatest causes of crippling among children. The number of children crippled by some diseases, such as rickets and tuberculosis, is decreasing, but there is no likelihood that cerebral palsy will be conquered soon. Surveys in several States indicate that each year seven infants with cerebral palsy are born per hundred thousand of the population.

Practically all these children are greatly handicapped in body, but only 25 to 30 percent are feeble-minded. The remaining large number should be trained and educated in such a way that they can develop into happy and capable members of society.

This is no easy task, but it can be approached with more chance of success if the child's parents, his teachers, and all workers concerned with him understand the conditions that bring about the problems in caring for these children. Let us ask, then, what is cerebral palsy?

Cerebral palsy is not a single entity; it represents several conditions, which are grouped together because they all are caused by injury or disease of some part of the brain.

Different functions of brain affected

The brain is such a complex organ, and it has so many functions, that a body condition resulting from injury or disease in one part of the brain is likely to bear little or no resemblance to one resulting from injury or disease in another part.

The chief functions of the brain are: First, reception of incoming stimuli, as in seeing, hearing, touching, smelling, and tasting; second, the work of the actual thinking part of the brain, in which the stimuli that come in are organized and reviewed; and third, the motor or activity work—the sending of outgoing stimuli from the brain to move the various parts of the body such as the

Excerpted from a more comprehensive paper by Dr. Phelps.

arms, the legs, and the speech mechanism.

In cerebral palsy, any or all of the three functions of the brain may be affected, according to where the injury is. Thus not only are the child's motor powers affected, but the sensory, and sometimes the mental powers as well. Many attempts to teach children with cerebral palsy have failed because only the motor disturbance has been given attention, and the child has been treated in the same way as if he had the motor disturbance that results from infantile paralysis, which is an entirely different condition.

It is not possible to consider as a whole the group of conditions known as cerebral palsy. It must be broken into its various types and these types must be recognized by anyone who is planning to teach these children. This does not mean that in order to teach such a child one must be medically trained, or must know the medical details of cerebral palsy. Rather, one must be familiar with the various types and be able to recognize them with a reasonable degree of accuracy in order to understand the difficulties in learning that these children have.

If a child has only one handicap, such as blindness, paralysis, deafness, or lack of speech, it is easier to plan ways of teaching him than if he is a child with cerebral palsy, who practically always has combinations of handicaps. Any one of the handicaps may be minor when considered alone, but when two or more are joined they may make the problem of teaching him very difficult.

In training a child with cerebral palsy we must remember that he has had his handicaps ever since he was born; and we must realize that many fundamentals such as alternating the legs, reaching, and grasping, which a normal child learns of himself early in life, must be taught to the child with cerebral palsy.

Muscles can act wrongly in various



Apparatus that guides him and aids him in maintaining his balance is helping this cerebral-palsied boy to learn to walk.

ways. For example, in infantile paralysis, it is simply impossible for the child to move his muscles when he wishes. In cerebral palsy this type of paralysis is seen only occasionally. The opposite condition, however, in which the child's muscles move whether he wishes them to or not is frequent in cerebral palsy. The child's arms or legs or face move without his making any voluntary efforts. This condition is called *athetosis*; it occurs in 30 to 45 percent of the children with cerebral palsy.

When muscles move involuntarily

In athetosis, when the child's muscles move of themselves, the involuntary motions will upset his attempts to make normal motions. The trouble that this causes to the child depends on what part of the body is involved.

For example, it may be the face, and many children have been wrongly clas-

fied as mentally defective because of grimaces, other facial contortions, drooling, and disturbances in speech, brought on by involuntary motions. Incidentally, such difficulties should be entirely disregarded when we are attempting to determine a child's true

cases are of this type. The fact that the proportion is so small makes it unwise to speak of all children with cerebral palsy as spastics, as so many persons do.

The true spastic has extreme stiffness in the muscles whenever he tries to move them. This slows up his motions and

one can see a definite difference between them.

Balance disturbed

The third type of cerebral palsy is *ataxia*, which represents about 10 to 20 percent of cerebral-palsy cases. Children with ataxia do not make involuntary motions, nor are their muscles stiff, but they do have severe disturbance of balance. Often they cannot control the motions of their eyes, and this tends to make them dizzy or otherwise uncomfortable when they try for long to fix their gaze on anything, such as a printed page. It is obvious that these children would have difficulty in sitting erect, in using the legs accurately in walking, and in using the eyes in reading and writing.

Intelligence may be damaged

About 10 to 20 percent of cerebral-palsy cases are represented by the fourth condition, which is called *rigidity*. This is characterized by a resistance in the muscles like the resistance felt in bending a lead pipe. It is usually intermittent, but generally takes place whenever the child attempts voluntary motion. It is associated with perhaps more damage to the intelligence than any of the other types of cerebral palsy. Rigidity is more closely related to spasticity than to any of the other types in its effect on muscular control and in its treatment.

The fifth type of cerebral palsy is known as *tremor*. About 5 to 10 percent of all the children with cerebral palsy have this type. It is characterized by rhythmical involuntary motions of the muscles. The child's mentality is usually good. Tremors are something like athetosis in their effect on the child's muscular control and in the treatment needed.

In all five of the types of cerebral palsy there are three fields of motor difficulty. These represent the legs with regard to locomotion, the arms with regard to self-help, and the speech and face mechanism. We are combining the speech and the face, since children with speech defects usually, although not always, have an accompanying lack of control of the facial muscles.

On the sensory side, the child with cerebral palsy may have difficulty with vision, owing to abnormal or involun-



Playing "telephone" is fun for Ina and Jo, who have speech difficulties that are due to cerebral palsy. This kind of play is helping them to relax while trying to walk, and they are learning to express themselves without tension.

mentality, which exists behind the mask of involuntary motion.

When the involuntary motion occurs in the legs, the child of course has difficulty in walking, and usually some difficulty in balancing.

If it is the arms that are affected, the result is like trying to write in a moving train or automobile.

The child may try to control the involuntary motion by holding himself very tense. But this does not help; in fact, it often makes the involuntary motion worse. The tension often becomes habitual, and so strong that the child finds that he can hardly let go. This attempt to hold still is not universal among athetoid children; it occurs in about half of them.

Two types easily confused

Spasticity is the second type of motor difficulty that occurs in cerebral palsy; about 30 to 45 percent of cerebral-palsy

makes them very laborious. But he is able eventually to accomplish the motion, and with a considerable degree of accuracy. The stiffness may disappear almost completely when the child is sitting still.

The spastic child, especially if only one part of the body is involved, often has decreased sensation. Such a child may make little use of an arm that fundamentally has fairly good function, because he is unable to feel clearly any object that he grasps or holds. He feels as though he were trying to use the hand covered with a heavy woolen glove. This would of course deter the child from using the arm in all sorts of activities. It would not hinder him so much in using his legs, since finer degrees of sensation are not so necessary for walking.

The athetoid and the spastic child can easily be confused, but by observing each type closely over a period of time

tary motions of his eyes, which would greatly affect reading and writing.

The athetoid child especially may have limited hearing. In some of the athetoid group there is a rather characteristic type of hearing defect, which is frequently overlooked. This defect is on a pitch basis entirely and is not related to the loudness of the sound. This hearing defect has been discovered in children even as old as 8 or 9 years, whose parents have never been aware of it.

Whether the child has this type of hearing defect can best be determined by studying the type of speech defect he has and the pitch at which his hearing is cut off. This can be done by noticing which sounds are lacking in his speech, since no child will use sounds that he does not hear some other person use.

When the point of cut-off is low, many words sound alike to the child, and he can hardly make out what people say to him. We can easily see this makes the child answer in a way that leads many grown people to consider him a behavior problem.

Some of these children are even considered mentally defective because they do not respond normally when spoken to.

Still others have had their speech defect wrongly attributed to athetosis in the tongue, with inability to form the words. Of course, athetosis does occur in the tongue, and there are athetoid speech defects that are definitely associated with limitation in proper use of the tongue, but we must not confuse these speech defects with those due to an unrecognized hearing defect.

It is not always possible to carry out careful audiometric tests on these children, and so we must place a great deal of dependence upon the type of speech defect and the determination of its cause.

If the child is consistent in certain omissions and mispronunciations, we can assume that the speech defect is due to a hearing defect.

The true athetoid speech defect, due to involuntary motion in the tongue, is entirely different in that the child may not pronounce a word the same way twice, since the involuntary motion in

his tongue can never be synchronized with the voluntary motion.

In the spastic child, on the other hand, there is little probability of an associated hearing defect, and the speech in the spastic is very characteristic. The tongue shows spasticity, and although the child has a definite speech defect the "language" can be learned by those associated with spastics.

The speech of the ataxic child is different from that of the other types because the position of his tongue is indefinite; he is not able to place it accurately.

It is obvious, therefore, that the treatment of these various types of speech defects will only be accomplished after very careful distinction is made between them.

Obviously a child with such motor and sensory difficulties as have been described, who must grow up in our complex environment, will have psychological difficulties that workers with these children should understand.

Types differ in psychology

The psychological limitations imposed on the child that does not walk are difficult to measure. A child's self-teaching is to a great extent dependent upon the fact that he is able to crawl around at first and later to walk around, touching all sorts of objects and coming in contact with a variety of materials. How much this environmental learning is limited by the child's inability to walk or crawl at the proper time is, of course, extremely difficult to determine.

It is equally difficult to measure the psychological limitations caused by the child's inability to use his arms in coming in contact with various materials and objects.

And when the limitation in the proper use of the arms and legs is combined with an eye defect, a hearing defect, or a lack of sensation, such as is found in the spastic, it is practically impossible to evaluate the child's potentialities for learning.

If a child cannot speak but has good control of the arms, and has no mental defect, he always develops a speech substitute or sign language of some sort.

However, if his limbs are affected so that he cannot develop a real sign language, then his way of communicating with others is definitely limited, and it is again impossible to measure the effect of this on his fundamental abilities. Such a child will develop a psychological set-up entirely different from the normal one.

Although the distinction between the types is much less in the psychological field than in the motor, there are a few fundamental psychological attributes



Weaving helps a cerebral-palsied child to learn muscle control of arms and hands. Bill can run a loom from a wheel chair.

which are observable in these children in their respective groups.

Thus, for example, the athetoid child as a rule is not fearful, whereas the spastic child is likely to be filled with fears of many kinds, and this considerably limits his activities. The ataxic child is about like a normal child with regard to fear.

Affection is highly developed in most athetoid children, whereas the spastic is likely to show affection only when seeking protection. The athetoid, typically, is extraverted and makes friends easily and is not particularly concerned about his handicap. The spastic, on the other hand, usually is introverted and is fearful of strangers, and as a rule

takes considerable time to make friends.

The athetoid child tends to show a great deal of rage or anger and is likely to have strong dislikes; the spastic, usually, is much slower to anger and does not stay angry long.

The child with rigidity and the one with tremor resemble the spastic and the athetoid respectively in these two respects.

It is very difficult when working with cerebral-palsied children to distinguish the psychological emotional set-up of

is combinations of difficulties that bring about the hardest problems; and that practically every one of these children has more than one handicap, caused by the disease.

When handicaps are combined

Which parts of the child's body are affected by his brain injury will have varying effects on his needs and on his learning.

If, for example, his legs are affected, he will need transportation, especially

to many cerebral-palsied children; and a hearing aid is often a step toward a child's learning to talk.

A case which may be cited at this point is that of a boy of 10, whose legs, arms, and speech were involved.

Much medical and surgical work had been done on his legs, to no avail, but little or no training had been given him in using his arms or in speech. He had had no schooling whatsoever because of his difficulty in speaking and in using his arms.

Training in use of his arms and in speech was begun, and after 3 years his arms were rehabilitated to the point where he could dress himself, wheel himself in a wheel chair, and take care of himself at the toilet. The speech was improved so much that he could be understood quite well.

It was decided that no further attention should be paid to the legs.

This boy was able to wheel himself in and out of his house, which was built on ground level; down to the corner store; and to a school in the neighborhood; and he was freed from the necessity of being cared for entirely by another person.

This case is given simply to bring out the relative unimportance of actual walking. Use of a wheel chair, with some training of the child to get in and out of it, is relatively satisfactory in most instances, and rehabilitation of speech and arms in cases of this sort is far more important than of the legs.



A speech therapist who understands Bobby's type of cerebral palsy is discussing his toys with him. She spends a short time with him daily, and keeps in touch with his teacher and his parents so that they can all work in the same direction.

a child whose mentality is fundamentally normal from that of a defective child. Of course, there are defective children among those with cerebral palsy, but the percentage of children with true mental defect due to damage to the actual thinking part of the brain—not the motor or the sensory part—represent only about 33 percent of the total number with cerebral palsy. In the presence of great difficulties in testing and evaluating the mental level in these children, it can only be said that all of them should be given every opportunity to learn, after all their various handicaps have been taken into consideration.

In helping the cerebral-palsied child to learn, we must keep in mind that it

when he is ready to go to school.

Involvement of the arms is important with regard to the child's being able to help himself in dressing and undressing, wheeling a wheel chair, and using the toilet; and, later, in turning pages and in writing.

The third involvement—of speech and face—is primarily a handicap in regard to the child's learning to talk. But, of course, involuntary movements of his face will affect his relations with other people, especially at school.

If the child's sight or hearing is affected, the usual methods for helping such children may be used; but the special types of hearing defects mentioned earlier should be kept in mind. Eyeglasses and hearing aids will be of use

If a child with cerebral palsy is to be given the best possible help, any person who is working with him should know enough about the various aspects of the disease to make sure that the efforts to teach the child are not wasted because the methods used are not suited to his needs.

When these various aspects of cerebral palsy are distinguished, and the needs of the child as an individual are recognized, we can help the cerebral-palsied child to lead a life that is as nearly normal as is possible in view of his handicaps.

Reprints available in about 5 weeks

EXPLORING THE PROBLEMS OF THE CEREBRAL-PALSIED CHILD

"Treat the child with cerebral palsy first as a child, then as a handicapped child, and last as a cerebral-palsied child," said Myer Perlstein, M. D., medical director of the Mandel Clinic, Michael Reese Hospital, Chicago, speaking at a conference on children with cerebral palsy that was held by the Children's Bureau March 26-28 at Washington.

The conference was the first one of its kind in that it consisted of a small group of experts in various fields, each of which is important in the care and training of the cerebral-palsied child. The fields represented included pediatrics; neurology; orthopedic surgery; nursing; physical therapy, occupational therapy, and speech therapy; medical-social work; psychiatry; psychology; and special education. These professional workers met to pool their experience in preparation for a major effort by the Children's Bureau and the State crippled children's agencies to help cerebral-palsied children, of whom it is estimated that there are 175,000 under 21 years of age in the United States.

It was pointed out at the conference that up to now little help has been available to any considerable number of these children, many of whom though normal in mentality cannot walk or talk, cannot dress and undress themselves, and of course cannot learn to support themselves in adulthood after they are grown up.

Many wrongly thought deficient

Many of these children are entirely neglected. Many whose handicaps are entirely physical are wrongly considered mentally deficient and are in institutions for the feeble-minded. Some are kept at home, but are hidden from neighbors and other persons. Many of these children, it was agreed, could lead happy and useful lives if only the services they need could be provided for them.

The special purpose of the conference was to review the needs of these children; to explore methods for providing special services to them; and to

formulate principles, policies, and standards that may serve as a guide to State agencies in the development of these services.

Several aspects of the special problems of the cerebral-palsied child were discussed, the medical, the psychological, the social, and the educational; and it was stressed throughout the conference that these problems can be met only through teamwork by representatives of several professions.

Individual plans needed

The conference agreed that a thorough appraisal of each child's condition is a necessity, and so is a plan of care developed individually for the child.

After the members had discussed, in several sessions, methods of meeting the needs of these children, and principles and standards of service in meeting their needs, the conference was formed into four committees: (1) On administration of services for cerebral-palsied children; (2) on the services themselves; (3) on facilities for providing these services, and (4) on personnel and training. Each of these committees included a member of the Children's Bureau staff.

The committee on administration, reporting to the conference on development of a satisfactory program for cerebral-palsied children, called for special emphasis on locating infants and young children with cerebral palsy in order that they may be helped in getting a better start in life.

In addition, the committee suggested that preliminary diagnosis or screening be done through field clinics in local communities; that each child's case be reviewed in a central diagnostic center for a thorough appraisal by a team of persons in the medical, psychological, educational, social, and special therapeutic fields concerned with cerebral palsy.

The committee on administration further suggested that State programs should provide all the necessary services. These were listed as medical, physical, occupational, and speech therapy;

special education and training; and vocational education and training; also education of the parents to help them in understanding the needs of their child and in trying to fulfill these needs.

The need for a special advisory committee, including representatives of voluntary agencies and parent groups as well as the various professions, to advise the State agency operating the program for children with cerebral palsy was pointed out by the committee on administration.

Consideration was given to the need for over-all medical direction and for coordination of the proposed services. It was agreed that a pediatrician with wide knowledge of growth and development and with neurological orientation would be well prepared to undertake such a position, but that a physician with some other background in the children's field, such as an orthopedic surgeon, also could serve effectively as director of these services.

The same committee urged joint planning on services for the cerebral-palsied child on the part of State agencies—not only the official State agency responsible for crippled children's services, but also other State agencies in the fields of health, education, and welfare.

In addition, the committee considered the types of children to be admitted to such a program, and agreed that a State program should accept, at least for diagnostic services, all children with cerebral palsy, irrespective of their mental status.

The types of services considered essential in a program for children with cerebral palsy were listed by the committee on services in its report. These are: Case finding, diagnostic services, treatment, recreation, education, vocational and social rehabilitation, and foster-home services.

The value of home life for the child was stressed, and the committee recommended that services should be provided in the child's own home as well as in treatment centers.

For the child who has a good mentality but whose physical handicap is so severe as to preclude hope for benefit from treatment, custodial home care should be provided, this committee reported. In such custodial homes, said

the committee, there should be opportunity for social companionship, recreation, and music appreciation, as well as for education.

It was agreed that the child with low mentality should, after he is carefully studied, be cared for in an institution for the feeble-minded. But before such a child is referred to the institution he should be taught, insofar as possible, to walk and to feed himself and otherwise to make himself more easily cared for.

Teamwork most important

The committee on facilities worked in close cooperation with the committee on services, as it felt that actual physical facilities were of less consequence than the services that the program could provide. That is to say, the important thing is that centers for children with cerebral palsy be developed in such a setting as will allow for consultation with a variety of medical specialists and allied professional workers as may be needed to give the child his best opportunity to develop. Such centers, it is hoped, will help to give the team of professional workers for the cerebral-palsied child a balanced point of view. Both committees recognized, however, the urgent need for suitable diagnostic clinics and long-term convalescent facilities for services to these children.

Basic training not enough

The committee on personnel and training stressed the fact that each member of the professional team concerned with the cerebral-palsied child needs special training, beyond the basic professional training, but made no recommendations as to how much time should be devoted to this special training, or what it should include. The possibility was considered that a few special units need to be set up, in connection with university clinics, where postgraduate training could be given to all the types of professional workers for the child with cerebral palsy.

The matter of trained professional personnel is urgent and is one of the greatest problems the various State agencies for crippled children's services will have to face in developing their programs for children with cerebral palsy, the committee agreed.

In conclusion, the conference pointed

out the great need for research in a number of fields, as a basis for the development of sound programs for children with cerebral palsy. Dr. Perlstein urged further research on the causes of the disease. Dr. Jessie M. Bierman, chief, Crippled Children's Services, California State Department of Health, urged that studies be made of the distribution of the disease in rural and urban areas, by race, by economic status, and by availability of medical facilities.

Study of the family histories of children with cerebral palsy is needed, according to Dr. Bronson Crothers, Children's Hospital, Boston. Dr. Temple Fay, medical director, Neuro-Physical Rehabilitation Clinic, Philadelphia, suggested the need for research in such matters as the speech mechanism.

The conference was in entire agreement that research was needed in determining the characteristics of the special preparation of each of the professional workers in the programs. Dr. Frank A. Disney, pediatrician, cerebral-palsy unit, Strong Memorial Hospital, Rochester, N. Y., told of research now going on at that hospital with regard to muscle function.

The following attended the conference:

Emily Adams, physical therapist, Oakman School, Detroit.

Dorothy Baethke, physical therapist, Chicago.

Bernadette Banker, superintendent, Sigma Gamma Hospital-School, Mount Clemens, Mich.

Dr. Harry V. Bice, psychologist, New Jersey Crippled Children's Commission, Trenton.

Dr. Jessie Bierman, chief, Crippled Children's Services, California State Department of Public Health, San Francisco.

Dr. R. E. Bruner, assistant medical director, Children's Rehabilitation Institute, Cockeysville, Md. (representing Dr. Winthrop M. Phelps).

Miriam Buncher, medical-social worker, Detroit Orthopedic Clinic, Detroit.

Dr. Earl Carlson, Pompano, Fla.

Dr. Bronson Crothers, Children's Hospital, Boston.

Dr. Frank A. Disney, pediatrician, cerebral-palsy unit, Strong Memorial Hospital, Rochester, N. Y. (representing Dr. Plato Schwartz).

Dr. Lucille Eising, orthopedist, cerebral-palsy unit, University of California Hospital, San Francisco.

Dr. Temple Fay, medical director, Neuro-Physical Rehabilitation Clinic, Philadelphia.

Marjorie Fish, director of training courses in occupational therapy, Columbia University, New York City.

Esther Hutchinson, physical therapist, Ohio State Department of Education, Columbus.

Dr. Christine Ingram, director of special education, public schools, Rochester, N. Y.

Carol Jensen, consultant on education of the physically handicapped, California State Department of Education, Sacramento.

Dr. Elise Martens, consultant in special education, United States Office of Education, Washington, D. C.

Manon McGinnis, psychiatric social worker, Children's Hospital, Boston.

Henrietta McNary, director, school of occupational therapy, Downer College, Milwaukee.

Dr. Edith Meyer, psychologist, Children's Hospital, Boston.

Dr. Veronica O'Brien, medical director, cerebral-palsy unit, Neurological Institute, New York City.

Dr. Myer Perlstein, medical director, Mandel Clinic, Michael Reese Hospital, Chicago.

Helen Porteus, social-service department, Michael Reese Hospital, Chicago.

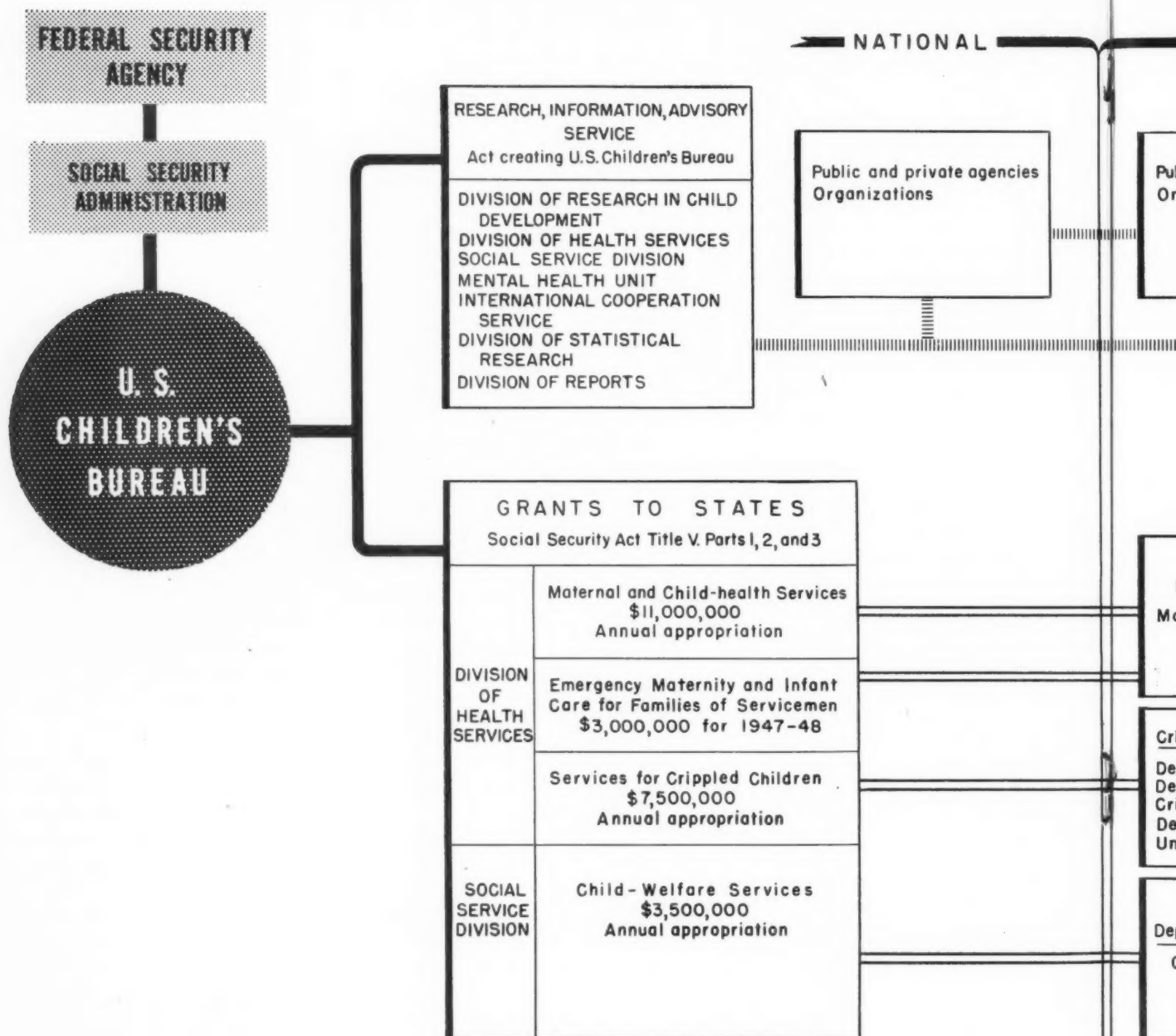
Clare S. Spackman, assistant director, Philadelphia School of Occupational Therapy, Philadelphia.

Dr. L. E. Wiley, professor of psychology, Beloit College, Beloit, Wis.

Grace Woolfenden, supervising principal, schools for crippled children, Oakman School, Detroit.

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HOW U. S. CHILDREN'S BUREAU SERVICES

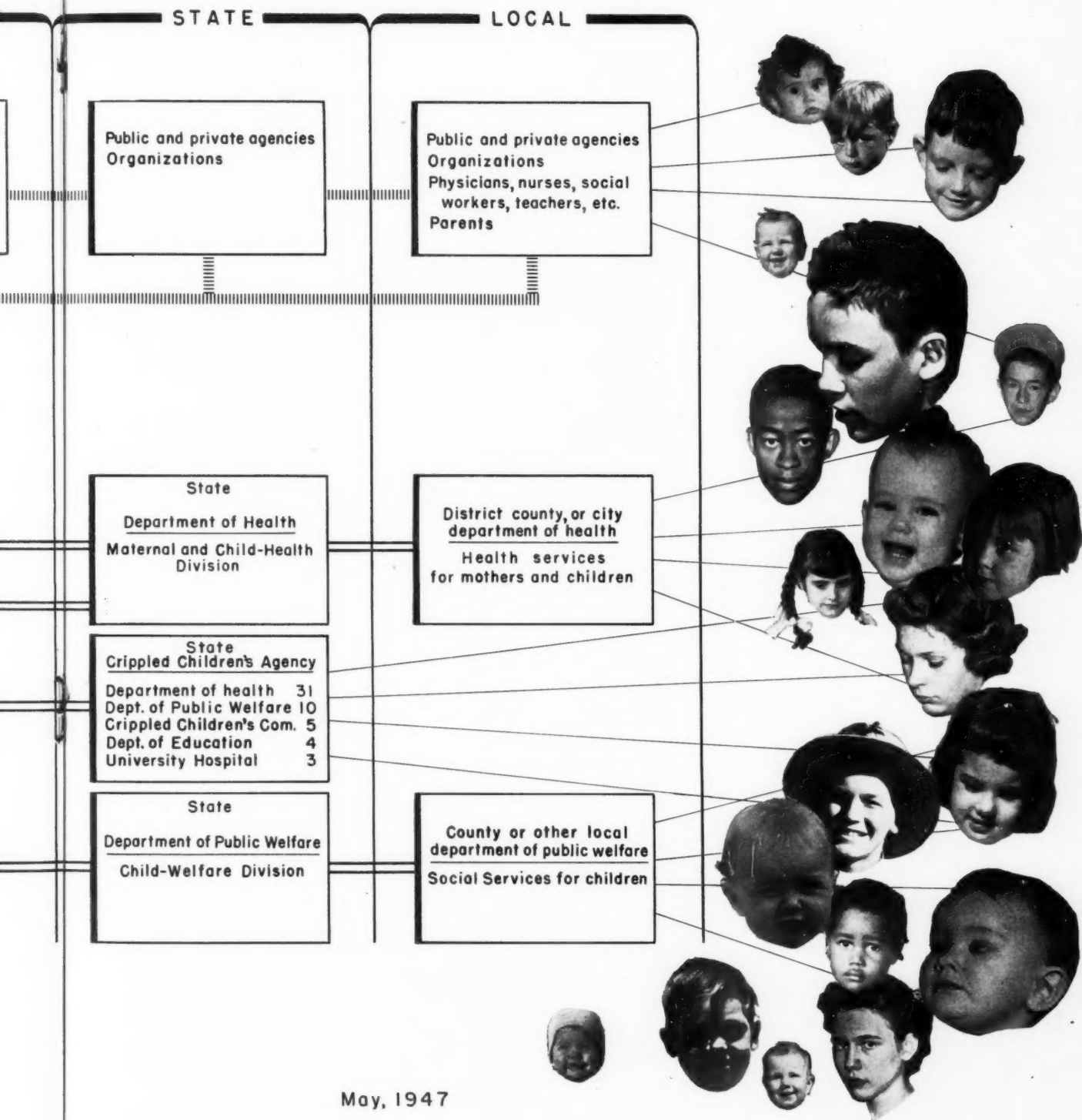


==== Federal and State grants

The term "State" includes the 48 States, the District of Columbia, Alaska, Puerto Rico, Hawaii, and the Virgin Islands.

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SERVICES REACH CHILDREN



May, 1947

WHAT THE BIRTH RECORD MEANS FOR A CHILD

HELEN C. HUFFMAN, *Social Science Analyst,*

National Office of Vital Statistics, U. S. Public Health Service

"THE PURPOSE of a birth certificate ain't to prove that you've been born—but when, where at, and who to." That's the way Will Rogers put it. And for most people the birth certificate is just that. For thousands of people it serves as necessary proof of age, of citizenship, and of relationship to other members of a family. Sometimes, however, the birth record is also a public announcement of a person's illegitimacy; of his "bad blood," because his mother had syphilis; or of his "criminal tendencies," because his father was in a penitentiary at the time of his birth.

Social implications of photostatic certified copies

Through the years the content of the birth certificate has grown from a few legal items to include about 50 items of information needed for medical and statistical purposes. Had vital statisticians known a generation ago that some five million copies of birth certificates would now be issued annually, they could have planned better. They might have foreseen what would happen when the complete record is placed in anybody's hands. They could have designed the certificate so that it could be reproduced in sections. A photostat could then be made of the parts a person needs for a particular purpose and nothing more. Medical and statistical data could have been placed in a confidential supplement, which would never appear on a certified copy.

Just what is it about birth records that causes trouble? It is not the birth certificate itself. Every item on it is valuable to the child. The difficulty comes with the practice of photostating the entire record as the certified copy. Because the whole record is given out, millions of people who use the birth record for proof of age, citizenship, and parentage, receive with this proof all

the other facts on the record—facts which were never intended for public view. These facts, in the various States, may include information about complications of pregnancy and delivery, mother's test for syphilis, crippling conditions of the infant, and illegitimacy.

All birth records contain private information. It is simply not the business of the general public that you are the fifteenth child or that your mother had six still-born babies, or that you were born during the seventh month of her pregnancy.

Birth records affect the lives of people in an endless variety of ways. I was in a State registration office when a young man requested his birth record. When he looked at the photostatic copy he was quick to express his protests. He said that a few months earlier, he had been offered a responsible position, which he planned to accept, but at the last minute the offer was withdrawn without explanation. Now he realized that in the investigation of his fitness the employer must have obtained a copy of his certificate. The entry on the birth record for "Occupation of father" was answered, "In an insane asylum." The fact was that the father was the chief psychiatrist in a hospital for mental illnesses, not a patient.

In this case the harm done to the young man was due to an error in the birth certificate, but it would not have happened if the registrar's office were not following the practice of giving out a certified copy of the whole certificate whenever any of the recorded information is needed.

Now that the war demand for birth certificates is over, there is time once again to plan. We cannot go back and undo the harm that was done to many

Condensed from paper given at the National Conference of Social Work, San Francisco, April 13-19.

thousands of people by unnecessary revealing of information that was on their birth certificates. But we can now help to bring about better methods of issuing certified copies of birth records all over the country. We can also improve our birth-registration programs so as to make the record do its job as the link between the child and the service he needs.

Who are the children needing help?

Who are these children who can be helped by a universally good birth-registration program?

They are the babies whose births do not get registered at all, many of whom are in need of nursing and medical care. Public health agencies are ready to give this care if only they know of the babies' existence.

They are the babies with crippling conditions at birth who do not become known to their State crippled children's agency.

They are the children born out of wedlock, and the mothers of these children, whose personal affairs become public knowledge through loose handling of the baby's birth record.

They are the legitimated children whose original records were falsified by misguided mothers, attendants, and social workers, children who cannot obtain a correct birth record without going into court and revealing the whole story.

They are the adopted children for whom nobody took the time to file a certificate showing the facts as they existed at the time of birth—children who go through life feeling a great need to know who were their natural parents.

They are the children entering school whose birth record sets them apart from their playmates because it shows they were born out of wedlock. Do you know that one State actually issues white birth records to legitimate children for school entrance and orange-colored records to children registered as illegitimate? Think what this means to the child with the orange-colored certificate.

A few years ago many States issued for the child born out of wedlock a certificate that isolated him as distinctly as does the orange-colored certificate in the State just mentioned. Fortunately today there are only a few States

that permit this type of discrimination. Birth registration has come a long way, but it still has a long way to go. In each State we find some good practices, and there is no reason why these cannot become the common practice in all the States. If only we could all get together and pool our experience, every child in the country could realize the maximum benefit from his birth record.

A hypothetical State program

By bringing together techniques from a State here and a State there, we can construct a hypothetical model State to see how a good registration program would operate. We can imagine a baby born in the State of X, and follow his birth certificate to see what it means to him.

Because many States prepare certified copies of birth records by means of a picture process, the format of the record assumes importance. The certificate could be arranged so that the legal items of name and date and place of birth could be placed at the top of the form. As a second portion, information about the parents could be entered. Then, in a confidential part of the record, the doctor could enter the numerous items of important statistical and health information. The question of legitimacy or illegitimacy would also be placed in this confidential part. The certified copy could then be made by taking a picture of only the first section when a person needs proof of birth place

and birth date. The second portion could be included in the picture when a person needs proof of parentage. The confidential information would never be given into public hands.

Here is the course that the birth certificate follows in the hypothetical State. The physician or midwife attending the birth completes the record and mails it to the local registrar, who may or may not be a member of the staff of the local health department. When the local registrar receives it, his job is to look after the validity of the record as a legal document. He passes the certificate on to the local health officer, who uses the record primarily as a medical document. The local health officer then sends it to the State health department, where the registrar uses it as a statistical document and thereafter safeguards it as the child's best proof of birth date, citizenship, and parentage.

Birth record confidential

At each of these steps the welfare of the child is considered. In the hands of the local registrar, the birth record becomes confidential. He refuses to release any information for advertising purposes. He refuses to permit the town busybody or any credit company to see it. Backing him up is a law which specifies that access to the record can be given to no one except authorized agencies. He makes sure there is nothing on the nonconfidential part of the record which would be detrimental to

the child if it appeared on his certified copy. "Occupation" of father and mother are reviewed to be sure that these entries give only the usual occupations and do not mention that a parent is in a penitentiary or in a hospital for mental diseases. He makes sure that the result of the mother's test for syphilis is not shown on the legal part of the record, and that the word "illegitimate" or "bastard" is not written across the face of the record. But, you say, it is obvious that birth records should not contain statements of this kind. Yet in one State today the law still requires the doctor who attends an unmarried mother to write "illegitimate" across the face of the certificate of the baby.

In the hands of the local health officer (still in State X) the record is carefully reviewed for health purposes.

If the record shows that the baby was delivered by a midwife or that the mother was not seen by a physician during pregnancy, or if the record suggests that nursing care may be needed, a nurse visits the home and explains to the mother the need for medical care for herself and her baby and tells her about the postnatal and well-baby clinics.

If the nurse finds a need for case work or financial help, she gets in touch with the welfare office. Any crippling condition (such as clubfoot, cleft palate, or harelip) reported on the record is referred immediately to the crippled chil-

This mother is giving the doctor who delivered her some information needed for the baby's birth certificate. It is the doctor's duty to fill in the certificate and send it to the registrar.



After the health department received this baby's birth certificate, a member of the staff told the mother about the well-baby clinic, and invited her to bring her baby to it.



dren's service. Corrective measures can then be begun at the time when correction can be most effective. If the record shows that the attendant at birth failed to use a prophylactic drug in the baby's eyes or that the mother had not been given a test for syphilis, the health officer gets in touch with the attendant.

If a midwife attended the birth and she is not enrolled in training classes, she is told why she must attend classes or stop practicing.

The record is checked with the register of rheumatic-fever cases known to the health department. If the mother has a history of rheumatic fever this fact will be kept in mind, and the baby will be followed through his early life and school years to be sure that he receives special periodic examinations.

The record is also checked with the venereal-disease and tuberculosis registers. If the mother or father is known to have syphilis or tuberculosis the baby will be followed up so that he can be given special tests for as long a time as the physician considers necessary.

An immunization card is made, so that the mother can be notified at the proper times for having the baby immunized against diphtheria, whooping cough, tetanus, and smallpox. The certificate is then forwarded to the State health department of our State X.

Time for the twins' vaccination against whooping cough, the public-health nurse reminds the mother at one of her visits. As this family's home is away up in the hills, the nurse first heard of the twins through their birth certificates.



In the State office of vital statistics, the registrar makes a photostatic picture of the certificate and sends it to the mother. Accompanying the picture is a form on which she can request the correction of any mistakes.

Mistakes *do* happen! Sometimes they happen in ways that nobody could foresee. I once had a visit from an irate father who came to me about an entry on a birth certificate. It seems that when the child was born a hospital employee stepped into the waiting room of the maternity hospital, saw a man pacing back and forth, and asked his name, occupation and age. She failed to ask him if he were the father of the child. It developed that the father was away and his uncle went with the mother to the hospital. If the mother had not had an opportunity to review the record, it is possible that this mistake might have remained for a long time and caused the child considerable embarrassment at some future day.

A program composed of the best practices from all the States would have special procedures for a child born out of wedlock.

The registrar would write to the mother and explain that if the baby's father is willing to have his name appear on the certificate as the father, he may send in a signed statement to this effect. The registrar would also explain to the mother that if she and the baby's father marry each other at any time in the future, they may send in a copy of the marriage certificate and the father's acknowledgment of paternity. These documents would be matched with the original record and filed away, and thereafter could be seen only on court order. A new certificate would be prepared, showing that the child's parents were married to each other.

The certificate would then be passed on to the statistician. In his hands the facts of birth are converted into symbols and punched into a card. The punched card for the baby is run through tabulating machines with the cards of all the other babies born in the State. The totals are studied along with those obtained from death and stillbirth records and with population figures.

With this information year after year, public authorities can predict with reasonable accuracy what will

happen to our population. School officials can tell how many children will be going to school 6 years from now. City planning commissioners can determine where housing projects are needed most. Health officials learn what kinds of clinics and hospitals are needed and where they should be placed.

Information on the number of children born with crippling conditions and the types of such conditions provides a basis for planning services for crippled children according to their needs.

Social-welfare groups can find out where to place recreational facilities and will know the relative sizes of the groups that they must consider by age and sex.

Vital statistics needed

The uses of vital statistics are endless. During the war a Government official sent to the National Office of Vital Statistics a frantic request for estimates of the number of babies who would be born in each State during the following 6 months. He explained that he must have the information in order to decide how many diapers the manufacturers should make and where they should be distributed. He said that the number of babies far exceeded the limited supply of diapers on hand, and, he concluded, "the situation in many parts of the country today is very wet."

Turning again to a program made up of the best in registration, we see that safeguards must be taken to document and protect the legal records of adopted children. In States having sound registration programs, parents adopting a child can look to the registrar to obtain from the court a report of the adoption. They can be assured that the registrar will link this report with the original birth certificate of the child, carefully seal the two documents away from public view, and prepare a new birth certificate on which the baby is shown to be their legitimate child.

Let us suppose that our child is now a young man and needs proof of age and citizenship from his birth record to present to his employer. Let us suppose that his record contains some bit of information which might affect his chance of getting the job. In a good State program the registrar no longer

(Continued on p. 206)

COUNCIL PREPARES FOR NINTH PAN AMERICAN CHILD CONGRESS

ELISABETH SHIRLEY ENOCHS, *Director,*
Inter-American Cooperation Service

ON APRIL 25, official representatives of 12 of the 18 member countries attended the regular annual meeting of the International Council (or governing body) of the American International Institute for the Protection of Childhood, in Montevideo, Uruguay.

Plans for the Ninth Pan American Child Congress, which is to be held in Caracas, Venezuela, January 5-10, 1948, occupied a prominent place on the agenda. The Council approved the suggestion made in accordance with a recommendation of the Eighth Congress that the next regular meeting of the Council be held in the host city of the Ninth Congress, dividing its meeting into two sessions, one a day or two in advance of the opening of the Congress, and one after its adjournment, in order to take whatever action may be necessary on the resolutions to be adopted on that occasion.

Election of officers for the 2-year period 1947-49 resulted in the reelection of Dr. Gregorio Araoz Alfaro, noted Argentine pediatrician, who has presided over the Council since the foundation of the Institute; of the Secretary, Dr. Víctor Escardó y Anaya, of Uruguay, who has held this office since 1927; and of the Director, Dr. Roberto Berro, who succeeded the Institute's founder, Dr. Luis Morquio, after the death of the latter in 1935.

For the first time since its creation 20 years ago, the Institute this year elected a vice president, Katharine F. Lenroot, Chief of the United States Children's Bureau, who has been the official representative of the United States on the Council since this country, by joint resolution of Congress, became a member of the Institute in 1928.

In the official communication addressed to her by the other officers of the Council, following the meeting, it was stated that this action of the Council was "in recognition of her intelligent devotion to child welfare, to the unfailing steadfastness with which she has

participated in the work of the Institute, and in recognition of the moral support given us on all occasions by the country which she has represented in this organization."

Prior commitments had made it impossible for Miss Lenroot to attend the Council meeting. The United States was represented by the writer, as alternate for Miss Lenroot, and by the resident delegate in Montevideo, Edward J. Sparks, Counselor of Embassy, and *Chargé d'Affaires* of the United States during the present absence of an American Ambassador to Uruguay. The statutes of the organization provide that each member country may have two representatives, a technical delegate and a resident delegate; that is to say, a representative residing in Montevideo, either a diplomat or some other qualified person, who can carry on relations with the Institute between meetings of the Council and represent the technical delegate if the latter is unable either to travel to Montevideo or to send an alternate.

In 1943 the Council voted to establish three technical departments—of health, education, and social service. The health department, under the direction of Dr. Víctor Escardó y Anaya, has been most active. After making a survey of rheumatic fever on the American continent, the results of which were published in the quarterly bulletin, the Institute sought to make notification of this disease compulsory. A resolution to this effect was approved by the recent Ninth Pan American Sanitary Conference, and the Institute was informed by the Paraguayan delegate to the Council meeting that his country is the first to issue a decree putting this recommendation into effect. The Ecuadorean delegate reported that similar action is about to be taken in his country.

Of special interest to the delegates from the United States was the report on the assistance given by the Institute to our Department of State in making new Spanish translations of three bulle-

tins of the Children's Bureau: "Prenatal Care," "Infant Care," and "Your Child From One to Six." Under a contract entered into between the Institute and the Central Translating Division of the Department of State, the Institute engaged three competent translators to translate the new, revised English editions. The Director and Secretary of the Institute gave their time to supervision and revision of the work of the translators, and the manuscripts of the Spanish texts were sent by air mail to the Institute's representatives in the other American Republics for the checking of terms which, because of the wide variations found between the different American countries, cause expressions familiar to every mother in Central America to be almost unintelligible to a mother in the Andean countries or those on the River Plate. Upon return of the manuscripts the Institute compiled a glossary of these varied terms, which will be a feature of each of the three bulletins in its new Spanish version.

The Institute took special note of the action of the General Assembly of the United Nations in creating the International Children's Emergency Fund and voted to communicate with the Secretariat of UN, expressing its interest in this mark of concern for child welfare, and inquiring as to the possibility of designating someone to represent it as an observer, in order to keep adequately informed concerning projects of the world organization in the field of child welfare.

Definite plans are being made by the Director General of the Institute, Dr. Roberto Berro, to attend the Ninth International Conference of American States when it meets in Bogotá, Colombia, in December 1947, to review the Inter-American system of which the Institute has now been a part for 20 years. Meantime strong efforts are being made to activate the Institute's departments of education and social service, which have been held back by financial limitations (the new system of quotas adopted last year gives signs of helping this situation) and to secure adherence of the three nonmember countries (Haiti, Nicaragua, and Panama) before the Institute's twentieth birthday on June 9.

BIRTH RECORD

(Continued from p. 204)

issues photostatic pictures as the usual certified copy. Instead, birth cards are issued.

The birth card, showing name, sex, birth date, and birthplace, is a pocket-sized certification, sealed in plastic. It was developed by the Council of the American Association of Registration Executives. One of the major purposes of the birth card is to provide a certification that omits unnecessary statements and at the same time is identical in format for all people. (For further discussion of the birth card see *The Child* for August 1946.)

We have traced some of the major benefits a child can receive from his birth record. These are not utopian dreams. They are practical realities in a few of the States today. Many civic groups have been aware of bad registration practices in their communities, but they did not know where to turn to find out what would be better. Fortunately this handicap no longer exists. The National Office of Vital Statistics, United States Public Health Service, Federal Security Agency, Washington, D. C., has collected a wealth of information on the laws and procedures and practices of all the States, and now has this information in usable form. Small groups of interested citizens have in the past few years worked to improve birth registration, and have realized most gratifying results.

Looking at the over-all field of child care, we realize that almost all community health or welfare projects can use to great advantage the birth, death, and stillbirth registrations. The registrar's office cuts across nearly every field of child care. His office provides one of the basic tools of every health program. Children in any State will not fare very well until the registration program is sound through and through. To do the total job well, persons interested in the welfare of children should assist the registrar in his efforts to bring his program in line with the best practices to be found anywhere in the country. By working together for a few years, we can transplant our so-called model program from this paper to 48 actual States.

Reprints available in about 5 weeks

IN THE NEWS

Great Friend of Children Retires From Active Life

The Child cannot fail to take note of the retirement from active work last February of Homer Folks, for 54 years Secretary of the New York State Charities Aid Association.

Mr. Folks, the year after he became the executive of that pioneering agency, secured the approval of the association for the establishment of an agency for aiding homeless mothers to care for their children; and 4 years later the association inaugurated both a child-placing and adoption service and a program of helping counties to establish county agencies for dependent children—the forerunner of the modern public child-welfare service programs in county welfare departments. In 1902 Mr. Folks' historical study, "The Care of Destitute, Neglected, and Dependent Children," was published, and for many years remained the standard work in this field.

To the Children's Bureau, Mr. Folks' part in the movement leading to its establishment, his continuing inspiration and helpful counsel through the years, and particularly his part in three of the four decennial White House Conferences on children, make him a very special friend and associate. Mr. Folks was appointed by President Theodore Roosevelt as vice-chairman and presiding officer of the first White House Conference on Dependent Children, in 1909. His overseas service after the first World War made it impossible for him to participate in the second White House Conference, but in 1929 and 1930 he was chairman of the committee on dependent and neglected children, of the White House Conference on Child Health and Protection. He took a leading part in the organization and work of the 1940 White House Conference on Children in a Democracy as a vice-chairman of the National Citizens' Committee, set up to carry on follow-up activities.

Of the four White House Conferences, in a 1940 paper entitled, "Four Milestones of Progress," Mr. Folks said: "Each Conference exerted a direct and powerful influence on child welfare."

Mr. Folks' kindly humor and the outreach of his imagination are illustrated by his speech at the preliminary session of the 1940 White House Conference.

"In planning for this 1939 Conference," he said, "we have been looking ahead, not to 1940, but to 1980, or thereabouts. Somewhere within these United States, within the past few years, was born a child who will be elected in 1980 to the most responsible office in the world. . . . We cannot guess his name or whereabouts. He may come from any

place and from any social or economic group. He may now be in the home of one of the soft-coal miners, or in the family of a share-cropper, or quite possibly in the home of one of the unemployed . . . or he may be surrounded by every facility, convenience, and protection that money can buy. Very likely his home is on a farm . . .

"If we could unroll the scroll of the future enough to know his name and whereabouts, how many things we would wish to have done for him, how carefully we would wish to guard his health, his surroundings, his associates, his travels, his ambitions—and what a gorgeous mess we almost certainly would make of it. . . .

"Since we cannot know his name or address, we have only one opportunity to see that the President of the United States in 1980 will be prepared for his job. We must decide what are the major needs of all children who are to become useful, competent, public-spirited citizens. We must, seriously and without delay, see that all the needful steps are taken, and that these minimum provisions are made available for all the children of the United States—for every last one."

The staff of the Children's Bureau rejoices that they can continue to look to Mr. Folks for counsel and encouragement.

Katharine F. Lenroot

Dr. Eliot Chairman of U. S. Delegation to Health Congress in England

Resuming a series of annual meetings, halted by World War II, the Health Congress of the Royal Sanitary Institute met at Torquay, England, June 2-6. Dr. Martha M. Eliot, Associate Chief of the Children's Bureau, served as chairman of the United States delegation.

Mental-Health Radio Programs Available

"For These We Speak" is the title of an electrically transcribed series of eight radio plays dealing with various aspects of mental illness. Organizations desiring to assist in the sponsorship of this series over radio stations in their communities may address their inquiries to the Radio Section of the National Mental Health Foundation, Box 7574, Philadelphia 1.

FOR YOUR BOOKSHELF

YOUR COMMUNITY; its provision for health, education, safety, and welfare, by Joanna C. Colcord. Russell Sage Foundation, New York, 1947. 263 pp.

Since 1911 the Russell Sage Foundation has been publishing guides for community self-analysis, revising them and producing a new one from time to time as changes in world conditions have affected community emphasis on various social problems. "Your Community; its provisions for health, education, safety, and welfare" has been revised recently by Donald S. Howard, Director of the Department of Social Work Administration, Russell Sage Foundation, to meet the requirements of the new developments in many fields, particularly of housing, medical care, consumer protection, and public assistance. The new emphases range over such varying interests as rural dwellings, migrant and seasonal workers, and interfaith and interchurch cooperation.

CHILDREN AND LITERATURE.

Bulletin of the Association for Childhood Education, 1201 Sixteenth Street NW., Washington 6.

Novel ways of bringing children and books together are pointed out by workers whose original ideas will undoubtedly serve as the stimulating force behind many new projects. Warning: Such enthusiasm is catching.

REPORT OF THE COMMITTEE ON THE JUVENILE EMPLOYMENT SERVICE. Ministry of Labor and National Service. His Majesty's Stationery Office, London, 1945. 63 pp.

Great Britain's Committee on the Juvenile Employment Service, which included representatives of national and local governments as well as labor, industry, and education groups, recommends that the employment service should give vocational guidance to all boys and girls before they leave school and to all who are still in school when they reach the age of 17.

The committee emphasizes the importance of having the employment service receive from the school a complete and confidential record for each pupil; not merely a formal statement of school attainments, but an account of the young person's special aptitudes, interests, personal qualities, home circumstances, health—to assist the employment service in giving the right guid-

ance. It suggests also that supplementary verbal information from the teacher, the parents, and sometimes from a social agency may be helpful.

Many suggestions are given in the report for encouraging young people to look to the juvenile-employment office for friendly advice.

PUBLIC HEALTH AND WELFARE ORGANIZATION IN CANADA, by Harry M. Cassidy. The Ryerson Press, Toronto, 1945. 464 pp.

This book, a sequel to the author's "Social Security and Reconstruction in Canada," published in 1943, was written before the Canadian Parliament had authorized a national system of family allowances and the establishment of a Federal department of health and welfare.

The discussion of the principles involved in the reorganization of Canadian health and welfare services is pertinent to problems faced in many of our own programs. The author takes up the need for well-trained personnel and for provincial responsibility for setting standards and supervising local activities financed wholly or partly from provincial funds. He mentions also the desirability of variable grants to enable local units to meet their health and welfare obligations.

Discussing the advantages and disadvantages of combined or separate departments of health and welfare and the appropriate functions of each department, Dr. Cassidy concludes that preventive health services and public medical-care programs, including mental hygiene, are the function of a department of public health; and public assistance, child welfare, vocational rehabilitation, and probation and parole, of a department of public welfare.

Margaret S. Skillman

NURSING AND NURSING EDUCATION, by Agnes Gelinis, R. N. Fifth monograph in the series, Studies of the New York Academy of Medicine Committee on Medicine and the Changing Order. Commonwealth Fund, New York, 1946. 72 pp. \$1.

Miss Gelinis points out candidly the reasons for the dissatisfaction of the public with the present methods of nursing care; the relationships of supply and demand during World War II; and

the uneven distribution of nursing care for low-income groups. She refers very briefly to coverage of various groups through medical- and hospital-insurance plans.

Students of nursing were better qualified in 1945 than in earlier years, says the author, through the cooperative efforts of high-school counselors; the raising of requirements for entrance to schools of nursing; the wider use of psychological tests; improved curricula; expanded clinical facilities; and improved methods of accrediting schools. She lists the outstanding problems that remain to be attacked, such as organization and financial support; pre-nursing requirements and selection of candidates; improvement in teaching personnel and clinical facilities; increasing importance of guidance and placement programs; the use of auxiliary workers; and continuing and advanced education.

Lucile A. Perozzi, R. N.

CONFERENCE CALENDAR

June 17-20—National Tuberculosis Association. Forty-third annual meeting. San Francisco.

June 23-26—American Home Economics Association. Thirty-eighth annual meeting. St. Louis.

June 23-28—General Federation of Women's Clubs. Annual convention. New York.

July 6-12—American Physiotherapy Association. Twenty-fourth annual meeting. Asilomar, Calif.

July 9-13—First Pan American Congress of Pediatrics. Washington.

July 14-17—Fifth International Congress of Pediatrics. New York. This international congress was to have been held in Boston in 1940, but had to be postponed because of the war. Further information from the secretary, Dr. L. Emmett Holt, Jr., Bellevue Hospital, New York 16.

Aug. 4-8—American Dental Association. Boston.

Schoolgirls on our June cover are enjoying a ball game on their playground. Photograph by Federal Housing Authority.

Other credits:

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FOR THE CHILDREN OF ALL THE AMERICAS

June 9, 1947, marks the twentieth anniversary of the founding of the American International Institute for the Protection of Childhood, with headquarters at Montevideo, Uruguay. Through this great center of research and information, the American Republics share with one another their experience and progress in providing for the health, the welfare, and the education of their children and youth.

It would be impossible to review the accomplishments of the Institute without paying tribute to that great Uruguayan pediatrician, Dr. Luis Morquio, physician, teacher, and friend of children, whose vision and dynamic leadership inspired the resolutions of the Pan American Child Congresses that brought the Institute into being. The fact that the statue erected to the memory of Dr. Morquio stands in the park in front of the American Embassy in Montevideo has always seemed to me particularly symbolical of the close cooperation that exists between the Institute and the Children's Bureau of the United States. As Chief of this Bureau, and as the technical representative of the United States in the International Council of the Institute since the United States, by action of our Congress, became a member, I am deeply grateful for the privilege of having been associated with its development and for the opportunity that has been afforded

through the Institute for closer cooperation with the individuals and agencies in other American countries who are responsible for the health and welfare of children.

In his proclamation of Pan American Week, President Truman emphasized the fact that the inspiration and example furnished by the peaceful collaboration of the American Republics have contributed to the development of world-wide international cooperation through the United Nations for the welfare and security of all people everywhere. As we enter into a new era of international cooperation through the United Nations and its various specialized agencies, we have much to learn from the history and organization of the American International Institute for the Protection of Childhood.

As the president of the Eighth Pan American Child Congress, which met in Washington during the war period, in May 1942, I was deeply grateful to the Institute for its work in developing plans for the Congress, in reporting its results, and in supporting its resolutions and recommendations.

As a representative of one of the countries that are members of the Institute, I am grateful for the important contributions of the Institute to scientific knowledge about child health and welfare as evidenced by the special studies of nutrition, rheumatic fever, and poliomyelitis, made by the health department of the Institute, under the able direction of Dr. Víctor Escardó y Anaya, and I am happy that the Inter-

American Cooperation Service of the United States Children's Bureau, in its program of cooperation with the American Republics, carried out under the auspices of the Interdepartmental Committee on Scientific and Cultural Cooperation of the Department of State, has had the constant support of the Institute in this work.

Just as President Truman's proclamation points out that "The Inter-American system that has developed around the Pan American Union will be further strengthened at the Ninth International Conference of American States, to be held in Bogotá, Colombia, in December of this year," let us hope that the cooperation of the American nations on behalf of their children will be further strengthened at the Ninth Pan American Child Congress, to be held in Caracas, Venezuela, in January 1948, and that when our official delegates assemble on that important occasion, every one of the 21 American Republics will be fully represented.

It is in this spirit of gratitude for association between the United States Children's Bureau and with the Institute in the past and of happy anticipation of even closer ties in the future that I send greetings to the American International Institute for the Protection of Childhood on its twentieth birthday.

Katharine F. Lenroot

KATHARINE F. LENROOT,
Chief,
United States Children's Bureau.

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UNITED STATES CHILDREN'S BUREAU
Katharine F. Lenroot, Chief

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